STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 01 B. WING	08/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

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K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/20/12 Facility Number: 000131 Provider Number: 155226 AIM Number: 100274910 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, North Capitol Nursing & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This four story facility was determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the	K0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a Desk review on or after September 7, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 123 and had a census of 113 at the time of this visit. The facility was found not in compliance with state law in regard to sprinkler coverage and was found in compliance with the state law in regard to smoke detector coverage. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility services, a storage shed, which was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/23/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to ensure 2 of 2 vertical openings in the third and fourth floor sprinkler riser rooms and 1 of 1 vertical opening in the bathing room on the fourth floor are enclosed with construction having a fire resistance rating of at least one hour. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the third and fourth floor sprinkler riser rooms and the fourth floor bathing room by Room 411. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 2:25 p.m. on 08/20/12; a. the concrete flooring deck separating the third and fourth floor sprinkler riser rooms from the floor below each had two, two inch in diameter openings through which twenty cables were running through the openings. b. the concrete ceiling in the bathing room by Room 411 had a one inch in diameter	K0020	**K020** It is the practice of this provider to ensure that vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Vertical openings between floors are now enclosed with construction having a fire resistance rating of at least one hour. The indentified areas in the third and fourth floor riser rooms and the fourth floor shower room were seals on 8/21/12 by the Director of Maintenance. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected. The maintenance department received in-servicing	09/07/2012

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	tube running through a three inch by one inch hole in the ceiling. Each of the openings in the aforementioned locations were not enclosed with construction having a fire resistance rating of at least one hour. Based on interview at the time of observation, the Maintenance Supervisor acknowledged each of the openings in the aforementioned locations were not enclosed with construction having a fire resistance rating of at least one hour. 3.1-19(b)		from the Executive Director on 8/21/12 regarding fire inspection/prevention. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** In order to correct the practice, the facility developed a new systemic protocol. The Maintenance Director or his designee will inspect the vertical openings between floors on a weekly basis. He will monitor to ensure that openings are enclosed with construction having a fire resistance rating of at least one hour. If non-compliance is found, the issue will immediately be corrected in accordance with regulation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** A weekly inspection of verticals openings of the facility will be performed by the Director of Maintenance or his designee for four weeks and monthly thereafter, for at least six months, to ensure compliance has been achieved.	

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure a sprinkler head was installed in 2 of 2 fourth floor nurses' station closets and 1 of 1 Executive Director's Office closets to provide coverage for all portions of the building. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the fourth floor nurses' station and the Executive Director's Office. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 2:25 p.m. on 08/20/12, the fourth floor nurses' station has two closets which were each not sprinklered and the Executive Director's Office has one closet which	K0056	**K056 What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** It is the practice of this provider to ensure that sprinkler heads be installed and maintained in accordance with regulation. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** As of 08/24/12, both closets on the fourth floor as well as the closet in the Executive Director's office have been equipped with sprinklers. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected. The	09/07/2012

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	was not sprinklered. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the two fourth floor nurses' station closets and the Executive Director's Office closet did not a sprinkler head in closet. 3.1-19(b) 3.1-19(ff)		maintenance department received in-servicing from the Executive Director on 8/21/12 regarding fire inspection/prevention. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** In order to correct the practice, the facility developed a new systemic protocol. The Maintenance Director or his designee will inspect the facility on a weekly basis to ensure that sprinklers are installed, operable, and unobstructed. If non-compliance is found, the issue will immediately be corrected in accordance with regulation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** A weekly inspection of the facility's sprinkler heads will be performed by the Director of Maintenance or his designee for four weeks and monthly thereafter, for at least six months, to ensure compliance has been achieved.	

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K0062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.1 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect 8 residents, staff and visitors in the vicinity of the bathing room on the second floor by room 211. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 2:25 p.m. on 08/20/12, there is one sprinkler head in the bathing room on the second floor by	K0062	**K062** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** It is the practice of this provider to ensure that sprinkler heads be installed and maintained in operable manner in accordance with regulation. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** As of 08/23/12 the identified sprinkler head in the shower room on the second floor was adjusted to ensure compliance. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected. The maintenance department received in-servicing	09/07/2012

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	room 211. The sprinkler head is mounted on the ceiling but the sprinkler head does not protrude from the ceiling which served to obstruct the spray pattern of the sprinkler head. Based on interview at the time of observation, the Maintenance Supervisor stated the sprinkler head is not a recessed sprinkler head and acknowledged the sprinkler head spray pattern is obstructed by the ceiling. 3.1-19(b)		from the Executive Director on 8/21/12 regarding fire inspection/prevention. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** In order to correct the practice, the facility developed a new systemic protocol. The Maintenance Director or his designee will inspect the facility on a weekly basis to ensure that sprinklers are installed, operable, and unobstructed. If non-compliance is found, the issue will immediately be corrected in accordance with regulation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** A weekly inspection of the facility's sprinkler heads will be performed by the Director of Maintenance or his designee for four weeks and monthly thereafter, for at least six months, to ensure compliance has been achieved.	

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 29 portable fire extinguishers requiring a 12 year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect 8 residents, staff and visitors in the vicinity of room 410. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 2:25 p.m. on 08/20/12, the fire extinguisher located in the corridor near Room 410 had an inspection sticker and a collar affixed indicating the most recent six year test was completed in March 2006. Based on interview at the time of observation, the Maintenance Supervisor acknowledged it has been more than six years since the most recent six year test was documented for the fire extinguisher in the corridor by Room 410. 3.1-19(b)	K0064	**K064** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** It is the practice of this provider to ensure that fire extinguishers be maintained in accordance with regulation. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** As of 08/20/12, the fire extinguisher was removed and replaced in an effort to ensure compliance. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected. The maintenance department received in-servicing from the Executive Director on 8/21/12 regarding fire inspection/prevention.	09/07/2012

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			What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: In order to correct the practice, the facility developed a new systemic protocol. The Maintenance Director or his designee will inspect the facility on a weekly basis to ensure that fire extinguishers are maintained in accordance with regulation. If non-compliance is found, the issue will immediately be addressed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** A weekly inspection of the facility's fire extinguishers will be performed by the Director of Maintenance or his designee for four weeks and monthly thereafter, to ensure compliance has been achieved.	